MANAGED HEALTH CARE IMPROVEMENT TASK FORCE
NOVEMBER 22, 1997 SPECIAL BUSINESS MEETING MINUTES

These minutes were not available for Task Force adoption before its last meeting on January 5, 1998; therefore, this document was not formally adopted by the Task Force.

Saturday November 22, 1997
8:30 AM to 5:14 PM
Chamber of Commerce 12th Floor Conference Room
1201 K Street
Sacramento, California

I. CALL TO ORDER [Chairman Alain Enthoven, Ph.D.] - 8:33 AM

The eighth business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven at the Chamber of Commerce Building in Sacramento, California.

II. ROLL CALL AND DECLARATION OF A QUORUM - 8:37 AM

Task Force Administrative Assistant, Lawrence Ahn, took roll. The following members were present: Dr. Bernard Alpert, Dr. Rodney Armstead, Ms. Rebecca Bowne,
Ms. Barbara Decker, Alain Enthoven, Ph.D., Ms. Nancy Farber, Ms. Jeanne Finberg, Hn. Martin Gallegos, Dr. Bradley Gilbert, Ms. Diane Griffiths, Mr. Terry Hartshorn, Mr. William Hauck, Mr. Mark Hiepler, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Dr. J.D. Northway, Ms. Maryann O'Sullivan, Mr. John Perez, Mr. John Ramey, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni,
Dr. Bruce Spurlock, Mr. Ronald Williams, Mr. Allan Zaremberg, Mr. Steven Zatkin, and
Mr. Les Schlaegel.

The following Ex-Officio members were present: Ms. Marjorie Berte, Ms. Kim Belshe, Mr. Michael Shapiro, and Dr. David Werdegar.

III. OPENING REMARKS - 8:42 AM

Chairman Enthoven opened the meeting by stating that today's meeting was the second in a three day series of meetings and that today's meeting would not include any voting activities. He said that given the time constraints, members would be asked to work through the lunch hour and that lunch would be delivered. The Chairman also indicated his strong preference to end the meeting by 5:00pm today.

Chairman Enthoven then prioritized the papers for today's discussion in the following order: 1) Academic Medical Centers; 2) Physician-Patient Relationship; 3) Regulatory Organization; 4) Dispute Resolution; 5) Consumer Involvement, Communication, and Information; 6) Practice of Medicine; 7) New Quality Information Development; 8) Vulnerable Populations; and 9) Integration: A case Study on Women.

IV. OLD BUSINESS

A. Discussion of the Academic Medical Centers Paper - 8:44 AM

Dr. Karpf began the discussion by proposing two changes to the paper. The first change would be on the first page where it lists the hospitals associated with Academic Medical Centers (AMCs). Dr. Karpf suggested that rather than saying "…teaching hospitals studied in this report…," the word "listed" should be substituted for "studied" because the paper did not study all of the Academic Medical Centers in detail.

Dr. Karpf suggested a second change to the paper related to the last paragraph on page 2 under the discussion of Loss of Disproportionate Share. Dr. Karpf proposed that the language be changed to note that as Medi-Cal patients leave, traditional safety net providers have a real financial burden and are endangered. Mr. Rodgers felt that the system needed to be restructured to recognize the excellence of the Academic Medical Centers and to allow them to contract broadly throughout the system, rather than creating a mandated program for their support. Dr. Gilbert objected to the concept that AMCs are somehow "skimming" healthier patients under the managed care system; he felt skimming occurred more under the fee for service system.

Ms. Finberg stated that the issue of the effects on safety net providers goes beyond AMCs. In response, Chairman Enthoven proposed that the language read "AMCs and other safety net providers are concerned."

Mr. Lee and Ms. Bowne felt that the report should discuss the effects of managed care on the full range of health professions education such as physician assistant programs, pharmacy programs, dental programs, nurse practitioner programs and not just physician training programs. They agreed that the paper should explicitly state that only one component of health professions education was addressed.

Mr. Lee also brought up the point that managed care should be involved in residency programs. Ms. Bowne agreed but pointed out that most health plans contract with networks. In order for residents to be placed in managed care settings, networks would need to participate in residency programs.

Dr. Werdegar felt that the paper should not mislead the readers that university hospitals are the only academic teaching centers. Chairman Enthoven agreed and proposed language to clarify the issue.

Ms. Severoni proposed a change to the language regarding Medi-Cal patients and managed care: she suggested changing the word "transfer" to "movement", because transfer does not imply a choice. This change was supported by Dr. Karpf and Dr. Spurlock. However, Dr. Northway stated that involuntary transferring of Medi-Cal patients does in fact occur in some cases. Dr. Enthoven agreed to change the language.

Dr. Northway also proposed a language change regarding the statement "Medi-Cal recipients are moved to private hospitals." He felt that private hospitals were given a negative connotation and proposed that the language be changed to "from safety net providers to non-safety net providers."

Ms. Farber felt that issues about experimental care and denial of access to clinical trials should be addressed in the paper. Dr. Karpf agreed that it was a very important issue but that it would be discussed with other issues.

Dr. Rodriguez-Trias and Dr. Spurlock expressed concern about sources of funding for teaching as AMCs clinical revenues decrease. Dr. Spurlock felt it was unfortunate that the Task Force had not addressed the issue of all-payer funding. Dr. Spurlock and Dr. Rodriguez-Trias further discussed deficiencies in residency training, particularly the continued emphasis on inpatient care rather than primary care, which is more the focus of practice in the managed care environment. In response, Dr. Karpf stated that primary care is one of the main services of most AMCs, which are in fact competing in the managed care environment.

B. Discussion of the Physician-Patient Relationship Paper - 9:25 AM

Dr. Gilbert began the discussion by proposing changes in the term "physician-patient relationship" to "provider-patient relationship." He then clarified his intent in section E, number 4: if a consumer was assigned to see a doctor but the doctor was not available, the consumer should be informed if the consumer is re-scheduled to see another care giver (i.e. physician assistant (PA), nurse practitioner (NP)). He added, should the consumer choose or be assigned to see an NP or PA who was not available, no notification is necessary should the patient see another NP or PA. Dr. Gilbert also indicated that his recommendation was not intended to change the supervisory requirements or laws regarding NPs or PAs. The wording in the recommendations regarding this issue was stricken from the recommendations. Dr. Gilbert ended his opening remarks by proposing that physician-extender be changed to "advanced practice nurses" which would include nurse practitioners, clinical nurse specialists and certified nurse mid-wives. Also, physician assistants would be called as such rather than referred to as physician extenders.

Mr. Hiepler addressed the issue of disclosure. He proposed that if anyone is capitated in a system, it should be the plan's duty to explain those services that are capitated. Mr. Hiepler also suggested that information such as the amount of the capitation and who is capitated should be disclosed.

Ms. Singer recommended that a pilot project be conducted for working with the medical groups to determine a clear, simple, effective way to disclose compensation arrangements.

Dr. Karpf proposed two language changes. The first change, in section C "Informing Patients of All Options," was to strike the first sentence regarding increased patient participation under managed care because he felt that all patients should participate in their own care all the time, not just under managed care. Dr. Gilbert agreed and also proposed that the second sentence be stricken. By straw poll, the Task Force agreed to remove the two sentences.

The second language change proposed by Dr. Karpf, under section E "Physician Availability," recommended to strike "but make coordination and oversight more difficult." Dr. Karpf felt that physician extenders help coordinate care between the provider and patient.

Dr. Karpf also brought up discussion in section three page four, regarding the information disclosed to patients. Dr. Karpf felt that the recommendation "…and medical groups to disclose to patients the number and outcomes of prior procedures…" was ambiguous and could not be supported by most hospitals. The ambiguity comes from the interpretation of outcomes because outcomes could mean mortality, morbidity or functionality. The reason that he felt that the system could not support this was because there is so much information involved and the system currently used can not store this data.

Dr. Werdegar expressed his approval of the paper's emphasis on the patient provider relationship and also expressed that this relationship be preserved with the recommendations made in the paper. He added that informing patients of all options, while necessary to establish a good patient-provider relationship, should be discussed in the paper regarding quality measurement.

Hn. Gallegos proposed the title of this paper be changed to provider-patient relationship instead of physician-patient relationship. He said that upcoming legislation has changed to say provider-patient instead of physician-patient relationship. Ms. Singer stated the literature used, studied specifically the physician-patient relationship and so the paper used physician-patient relationship so that the paper would be accurate.

Hn. Gallegos expressed his dissatisfaction with the language in the paper regarding advanced notice of termination of the doctor or provider to the patient. Dr. Gilbert brought up two parts for discussion in this termination issue. The first was member noticing. The second involved due process in the termination of physician contracts. Dr. Gilbert suggested something similar to current DHS policy under Medi-Cal which states that members should receive 30 days notice in advance should their provider not be available to them.

Chairman Enthoven began discussion of the issue of providing a reason for non-renewal of a provider's contract. Mr. Williams felt that giving a reason for non-renewal would have unintended consequences and was a bad idea. Mr. Hiepler felt that some reason should be given to doctors for the non-renewal of their contracts to minimize lawsuits. Ms. Singer clarified existing law under the Knox-Keene Act, which states that there must be disclosure for termination but fails to mention anything for non-renewal. Ms. Singer also indicated that another group is working on a compromise regarding renewal. Dr. Spurlock further proposed that the Task Force allow for the other group to settle this issue because any recommendations now by the Task Force would hinder the group's ability to reach a compromise. Mr. Zaremberg added that when a contract is finished, there should be no reason required for non-renewal because the contract terminated on its own terms. In a straw vote, a requirement for non-renewal failed 8:16.

Ms. Bowne brought up discussion concerning the issue of continuity of care between provider and patient. Dr. Spurlock stated that patients change providers for various reasons, some voluntary and some involuntary. He proposed that language be included to distinguish these separate situations because if the patient voluntarily changes providers, this continuity of care should be not mandated. He also proposed that for those chronically ill or those who are in the second or third

trimester of pregnancy at the time when a provider is terminated by a plan for other than cause, the patient should be able to continue seeing their current specialty providers for up to 90 days or term completion of postpartum care to allow for transition care. In addition, the providers who treat patients during this transition must accept the plan's rates as payment in full, provide necessary information to the plan for quality assurance, and transfer all medical records with patient authorization.

Dr. Spurlock began the discussion of recommendation B regarding gatekeeper roles, primary care physicians and utilization review, particularly for chronically ill patients. He agreed that patients with severe, chronic, and complex illnesses should have access to ongoing care from specialists, but felt that some chronic illnesses could be appropriately treated by the primary care physician. He proposed that primary care providers be allowed to authorize extended or permanent referrals to specialists. He felt that this method would result in a discourse between the specialist and the primary care provider. Mr. Lee, Mr. Rodgers, and Ms. Finberg agreed with Dr. Spurlock's idea but Mr. Lee and Ms. Finberg felt that the idea should be mandated rather than "encouraged." Mr. Lee and Dr. Spurlock agreed to work out some language for voting at the next meeting.

Dr. Werdegar proposed that recommendation C "Informing Patients of All Options" be included in the physician-patient paper where freedom of communication is addressed. Mr. Lee agreed and further recommended that health plans be included in the requirement list. He also proposed that this recommendation should be restated in the consumer information piece. Mr. Lee also added the qualifying language "as appropriate outcomes are available."

Dr. Karpf suggested language changes to allow for outcomes to be made available. He proposed the language "all presently available outcome data should be made available." Dr. Alpert expressed his concern with the problem of practical implementation. Dr. Spurlock stated that self-reported information is biased and inaccurate and therefore cannot be used by consumers for meaningful information. Further, he stated that because there are so many different techniques in performing the same procedure, the consumer may not be able to understand all of the data and therefore this issue should be addressed in the informed-consent instead of outcomes section. Dr. Spurlock and Dr. Rodriguez-Trias proposed language to strengthen the informed consent process regarding the data collection of outcomes. Dr. Spurlock proposed that this issue be included in the paper on quality information. A straw poll was conducted and the changes were accepted.

Mr. Hiepler began discussion on recommendation D, financial incentives. Mr. Hiepler felt that since the patient pays for the procedure, the patient deserves to know the amount of the capitation and who is capitated. Also, Mr. Hiepler felt that disclosing this information would act as a safeguard against abuse. Dr. Gilbert agreed that there should be some information available to the patient such as what services the provider is capitated for and how much in terms of dollar figures. Dr. Gilbert also proposed a friendly language change of adding the word "scope" so that the new language would read "method and scope of financial arrangement." In a straw poll, Mr. Hiepler's recommendation was opposed 8:17 and Dr. Gilbert's language change was accepted without objection.

Dr. Gilbert began discussion on recommendation E4. He stated that if a patient is assigned or has chosen a specific physician, the patient should be notified if he is directed to an alternative provider such as a physician assistant (PA) or advanced practice nurse (APN). Mr. Rodgers added to the discussion that Dr. Gilbert's recommendation would affect county facilities, clinics, and residency programs because there is a constant change of providers in these settings. A straw poll was done and the idea passed. Later in the discussion, Ms. O'Sullivan proposed that whenever a primary care provider (PCP) is changed, the patient should be informed of that change ahead of time, whether or not it is from a MD to a PA, or PA to PA. Dr. Gilbert and Dr. Rodriguez-Trias both agreed with this proposal.

Chairman Enthoven moved that recommendation F5 be removed since it is already discussed in the consumer information paper. A straw poll was taken and it was agreed to be dropped.

Break - 11:00 AM - 11:15 AM

Chairman Enthoven resumed the discussion regarding Dr. Werdegar's proposal to add a recommendation regarding confidentiality. Chairman Enthoven agreed that this was an important issue and should be included in the recommendations. Dr. Werdegar and Ms. Griffiths proposed language to address this issue. Mr. Shapiro stated that currently some health plans are asking individuals to waive their right and that was considered consent as a condition for getting medical care. He recommended that patients shouldn't have to be forced to waive their right to confidentiality for purposes not related to care. Chairman Enthoven proposed the language addition "or shouldn't be asked to waive for purposes other than care."

PUBLIC COMMENT

1. **Catherine Dodd**- American Nurses Association of California.Ms. Dodd asked that because nurses participate in collaborative care, they should be included in the list of providers to participate in recommended blue ribbon panels. She also asked that APN's be protected by the same gag rules as physicians. She asked that the paper be more provider neutral.

Ms. O'Sullivan agreed and proposed a language change which would not distinguish doctors in the issue regarding the formation of the blue ribbon committees. Chairman Enthoven, Dr. Rodriguez-Trias and Mr. Perez disagreed and proposed that the language read "doctors and other health care providers." They felt that this would emphasize the idea to have other primary care providers on the blue ribbon task forces or committees. A straw poll was taken and the language from Mr. Perez was incorporated.

2. **Maureen O'Haren**- California Association of Health Plans (CAHP).Ms. O'Haren stated that there is already existing law regarding the issue of continuity of care. She stated that the law requires 30 days notification for termination but nothing for non-renewal. She also cautioned that requiring medical records be used only for health care issues would slow down the grievance process because plans would have to get the patient's consent to review the records. Ms. Griffith noted that the confidentiality language explicitly states that the provision and payment of care are included in the allowable uses.

3. **Beth Capell**- California Physicians Alliance- Ms. Capell expressed her concerns that Dr. Spurlock's amendments regarding the continuity of care was more specific than those stated in the Knox-Keene Act which could result in some situations which might be excluded. She also encouraged the Task Force to revisit the renewal issue.

4. **Mary Griffin**- American Medical Group Association. On the issue of continuity of care, Ms. Griffin stated that medical groups are moving to "Evergreen" (in perpetuity) contracts rather than one-year contracts with their sub-contracting physicians. She explained that Evergreen contracts are less expensive for the medical groups and that they exist on a continual basis until terminated.

C. **Discussion of Governmental Oversight of Managed Health Care Paper- 11:44 AM**

Executive Director Romero began the discussion by explaining that this paper is a consolidation of two earlier papers, the regulatory organization and streamlining papers. Executive Director Romero recommended that if an organization in the health industry bears financial risk, then its oversight should be consolidated in a single regulator. He also stated that the paper specifically recommends that regulation of preferred provider organizations (PPOs) and exclusive provider organizations (EPOs) be consolidated along with more traditional Knox-Keene Plans in the same organization. He stated that this consolidated regulator is responsible for quality and traditional financial regulation. Executive Director Romero stated that there were two ways to achieve this consolidation. The first method, as recommended by the paper, was a stand alone organization called the Office of Health System Oversight (OHSO). The second would be a re-configured Department of Corporations (DOC). Executive Director Romero also stated that the paper recommended a single appointed director for this new regulatory organization. Hn. Gallegos offered an alternative which was a board with a leader or chairman. Executive Director Romero asked Ms. Singer to explain the recommendation concerning the financial and quality audits. Ms. Singer explained that the paper recommended that solvency audits and quality audits be streamlined to eliminate redundancy. This would be accomplished by allowing a medical group to request that the DOC or the new regulatory authority identify organizations that could provide an audit that would be sufficient for all health plans conducting regulatory reviews. Executive Director Romero concluded his opening remarks by stating that the reason for recommending a single regulator was that a single regulator has the flexibility to adapt and encourage innovation in the marketplace.

Hn. Gallegos explained reasons for why he felt that a five member board would be more effective than a single appointee. He thought it would be difficult to find a single person qualified to take on all of the new duties. He advocated a five member appointed board with one full time appointed chairperson, similar to the Air Resources Board and Water Management Board structures. The board would have decision-making authority, not serve only as an advisory body. He felt this structure would create better opportunities for public input, accountability, and continuity.

Mr. Rodgers, Ms. Farber, Executive Director Romero, Ms. Skubik, Ms. Singer, and Chairman Enthoven discussed the issue regarding responsibilities of DHS and the

new regulatory organization. It was clarified that DHS would oversee the contractual obligations and OHSO would deal with the oversight of quality.

Mr. Rodgers expressed his concern regarding PPOs. He felt there would be fewer PPOs with a consolidated regulator, which overall would limit consumer's choice of plan types.

Comments from the members regarding a board or a single appointed leader included:

- Mr. Zatkin felt that there should be an appointed leader who can be held accountable.
- Mr. Shapiro felt that there is less stability with a single director, therefore a board would be more advantageous.
- Dr. Gilbert felt that a board promotes more public involvement and that this would help in credibility.
- Dr. Alpert agreed with Dr. Gilbert in that the public accountability builds credibility. He proposed a combination of a board with one person who is identified as the chair and the other board members are decision makers rather than advisors.
- Ms. Berte felt that a board is not effective. She felt that an executive director wouldn't be able to focus all of his/her time to running the agency. She also felt that public boards lack expertise and therefore public boards should have more of an advisory role rather than a decision making one.
- Mr. Schlaegel felt that there would be better accountability through an individual person rather than a board.
- Dr. Spurlock felt that there should be an appointed head and an advisory board. Having one person accountable would guard against board members arguing against each other and not actually achieving anything.
- Dr. Werdegar felt that the new oversight body should not be located in the Health and Welfare Agency, but should either be its own agency or an office with direct access to the Governor and with an advisory board.

In a straw vote, the Task Force approved the first sentence of recommendation 1-A, which called for the creation of a new oversight body.

Lunch – 12:45 PM - 1:10 PM

Chairman Enthoven resumed the meeting by discussing the second half of recommendation 1-A. Dr. Werdegar felt that the services of the Office of Statewide Health Planning and Development (OSHPD) could be provided through interdepartmental arrangements and that OSHPD would not necessarily have to be moved. Mr. Zatkin stated that he did not see the rationale in moving OSHPD to the new oversight body unless other health-related entities that OSHPD serves would also be moved. Ms. Farber agreed. Mr. Schlaegel was concerned that unless OSHPD was moved to the new oversight body, the data needs of the new body would be overshadowed by other legislative mandates on OSHPD. A straw poll was taken to strike the second sentence in recommendation A-1, which was accepted by a majority of the members.

Ms. Berte proposed a language change be added to clarify that the Medical Board not be included in the new agency.

Dr. Spurlock requested that the language about direct regulation of medical groups and IPAs be clarified to specifically refer only to those regulations described in the rest of the recommendations, rather than creating an "open checkbook" of regulation. Dr. Northway and Mr. Zatkin agreed.

Mr. Hartshorn felt that language in the recommendation be rigid enough but also flexible enough to adapt to changes in the future. Dr. Alpert felt that the first sentence allows a general and very broad definition for who will be responsible for medical care which allows for inclusion of future definitions of care. He stated that the definition given in the Medical Practice Act in 1867 does not apply to today's definitions.

Executive Director Romero stated that the intention of the paper was to have the OSHO fuse financial and quality audits.

Ms. Griffin stated that because medical groups are regulated by everyone that possibly could, the recommendation would result in over-regulation.

A straw poll in deleting paragraph B was not accepted.

Mr. Kerr felt that striking the paragraph would be premature because everybody has some advantages in this recommendation. He suggested that a study be done to find what is best for consumers, purchasers and medical groups and then evaluate the issue. He proposed that within one year the study be done and evaluated.

A straw poll was taken regarding Mr. Kerr's proposal which passed.

The following were comments in the discussion of Recommendation 1-C.

- Ms. Berte felt that too many changes made could hinder the new organization so she proposed the changes be made incrementally. She also stated that streamlining and coordination must be accompanied by technological improvements.
- Ms. Bowne cautioned against putting PPOs in the same regulatory structure as HMOs because she felt that this would result in less choice and less alternatives in dispute resolution.
- Mr. Lee asked for additional language about the need to increase integration and coordination between various state agencies in order to improve the system for consumers.
- Mr. Shapiro suggested inclusion of ex-officio, non-voting members (such as the Insurance Commissioner and Director of DHS) on the proposed new oversight body's board.

A straw poll was taken on recommendation C, which passed.

A straw poll was taken to see if the single appointed head with the advisory board was favored or an appointed board with an executive officer was favored. The appointed board was in favor 14:9.

Chairman Enthoven proposed a language change which would say streamlining "should" be done, not "could" be done. A straw poll was taken, which passed.

A straw poll was taken on the concepts contained in recommendations 4, 5, and 6, which all passed.

Chairman Enthoven, with regards to recommendation 7, proposed a language clarification “no change in jurisdiction”. A straw poll was taken, which passed.

Ms. Berte felt that recommendation 8-B had a suggestion of criticism towards counsel. Ms. Decker and Mr. Lee proposed wording changes. Chairman Enthoven agreed to change the language to clarify the concept of objectivity and continuity.

Mr. Rodgers felt that this new entity should not be a department of the state because it would be affected by hiring freezes. He felt that it should be a public entity but be protected from the rules of the state in order to operate more efficiently. Executive Director Romero expressed his concern that an entity with this much regulatory authority might need to be a governmental agency. Mr. Rodgers proposed that the entity’s governance be accountable to the public but the staff and the general processes be arranged through an authority organization. Chairman Enthoven asked Mr. Rodgers to prepare a memo on this issue.

Mr. Shapiro commented on recommendation 8-C on the language “consolidate minor amendments.” He felt that this was too vague and that the new oversight body should perhaps develop a method to consistently determine what constitutes a minor amendment. Mr. Shapiro also addressed recommendation 8-D. He stated that this evaluation had already been done. Ms. O’Sullivan recommended a friendly amendment which would strike “hire independent organizations to evaluate the use of the recent.”

The concepts in recommendations 8-A, B, C, and D, as amended, were approved in straw polls.

With the next recommendation, Chairman Enthoven proposed that health plans be able to implement, without being subject to retribution, material modifications submitted to the DOC that are stagnant for more than 60 days. Ms. O’Sullivan felt that instead of removing regulation after 60 days the delays creating the problem should be addressed. Mr. Rogers proposed that the DOC identify a reasonable time frame for reviewing each submitted modification and act within that time frame, rather than having one fixed time frame for every modification. The Task Force agreed on this concept.

Recess - 2:34 - 2:50.

D. Discussion of the New Quality Information Development Paper - 2:52 PM

Mr. Kerr began the discussion by stating that improved information should help consumers make better choices between health plans, providers, and treatments. He stated that it would also help providers improve quality of care, help public and private purchasers better determine value, and safeguard the public’s health. Mr. Kerr recognized that there is high cost in collecting data, so he recommended data collection only if it either helps providers improve the quality of care or helps consumers and purchasers choose quality health care. He also proposed that the

state should not duplicate private sector efforts but that the state and the public sector should complement each other. Mr. Kerr ended his opening remarks by stating that the risk adjusted payment issue was dropped from this paper since it was already approved in another paper.

Mr. Kerr proposed that the larger health plans should have electronic implementation by 2002 and that smaller clinics have electronic implementation by 2004. Dr. Northway expressed his concern that this recommendation was a very expensive venture. Ms. Decker felt that electronic records would facilitate in decision making and that even if it was expensive, it would be worth taking the first steps towards implementation. Dr. Karpf agreed on the importance of electronic records but was concerned about who would bear the costs. He advocated starting with a manageable goal in which all providers could participate and then developing longer term goals.

Mr. Kerr addressed recommendation 2. He proposed legislative oversight of the process of storing and keeping data. He proposed it be done by a blue ribbon committee made of consumers, providers and purchasers.

Dr. Spurlock expressed his concerns that it would be easy to get carried away with data collection and that this could get out of hand financially. He proposed that the data stick to a certain set or number of data elements to avoid enormous amounts of data storage. He proposed that as one data element is added, one should be dropped.

Mr. Kerr stated that recommendation 5 dealt with the opportunity to make major improvements in public safety. He stated that currently, there are no minimum safety requirements in health care and that this recommendation would form a blue ribbon group to address the issue. This committee would set up time frames to implement such improvements. He recommended that a standard baseline of safety standards should be set so that all patients would receive at least an established minimum quality of care. He clarified that the intent of the recommendation would not be to entirely close down entities that failed to meet the standards, but to close down only the relevant components of the entity (e.g., revoke their ability to perform coronary artery bypass graft (CABG) surgery if they did not meet CABG performance standards). He agreed to add language to clarify this issue.

Ms. Bowne believed that this issue is not a managed care issue but a basic issue and therefore outside of the Task Force's purview.

Dr. Spurlock felt that the key issue would be the enforcement component and questioned whether the new oversight agency should have that responsibility, but he agreed with the concept. He asked for additional language to clarify the role of accreditation organizations and suggested using process measures in addition to outcomes measures.

Dr. Alpert also agreed with the concept, but felt that there may need to be geographic variation in the standards.

Dr. Werdegar was concerned that this type of function is currently performed by DHS and should not be moved to the new oversight agency. Mr. Lee suggested that the

recommendation direct the appropriate agencies to look at the issue, rather than specify which agency should have the responsibility for safety oversight. Mr. Kerr agreed to make this change.

Chairman Enthoven was concerned about creating a culture in which people would intentionally not report mistakes, in order to avoid punishment or retribution. In response, Mr. Kerr noted that one alternative would be to set the standards, monitor them, and work with violators to improve their record, rather than closing down relevant components of their business.

Ms. O'Sullivan felt that this recommendation would allow the market to work.

E. Discussion of the Vulnerable Populations Paper - 3:55 PM

Mr. Rodgers began the discussion by giving a preview of the issues in this paper. He stated that the majority of the vulnerable populations are in government programs. He also stated that providers were lacking in the ability to diagnose vulnerable populations.

Mr. Rodgers stated that the concept of recommendation 1 was to improve quality of care to vulnerable populations by creating a benchmark. The recommendation would require government programs to only contract with plans that have the ability to track, identify, and report performance outcomes for vulnerable populations.

Ms. Bowne agreed with the concept but she felt that having the benchmark set too high would hurt the system. She felt that having outcome data would not be possible. She expressed her concerns that the best people to treat vulnerable populations might not be able to treat them because of the inability to have outcome data. Mr. Lee agreed with the technological feasibility and proposed that some stipulation should be included with the recommendation.

Mr. Rodgers stated that technology is available to have outcome data and that some plans do track certain individuals to manage costs. He gave the examples of diabetics and asthmatics. He further recommended that withholding premiums from providers would act as an incentive to implement this tracking.

Mr. Schlaegel felt that this should happen with all populations, not just vulnerable populations.

Mr. Lee suggested that in addition to the recommendation that the state selectively contract, the state should also use incentives such as withholds and should work with other purchasers to create common tracking and reporting on performance outcomes for vulnerable populations.

In a straw poll, the Task Force approved Recommendation 1 as amended.

Mr. Rodgers began discussing Recommendation No. 2, regarding reallocation of savings achieved through managed care to insuring the uninsured. Mr. Shapiro cautioned against identifying a particular source of funding for the uninsured. Several Task Force members asked for clarification as to where these funds would go.

Dr. Northway was concerned about redirecting Medi-Cal savings without first assessing the adequacy of current funding levels for Medi-Cal.

Discussion followed concerning how to address issues that are also discussed in other papers. Task Force members were concerned about time, consistency across papers, procedural issues, and additional nuances on previous recommendations when considered in terms of vulnerable populations. Dr. Rodriguez-Trias suggested that before the next meeting staff identify which of the vulnerable population recommendations had not been addressed in other papers and include only those in the next discussion of this issue.

Ms. O'Sullivan presented an additional recommendation regarding a new annual report to the Legislature from DHS on the impacts of Medi-Cal managed care. Task Force members discussed which of the aspects of the recommendation were already required by Medi-Cal contracts and how much effort such a report might require. Mr. Lee suggested that DHS work with other organizations to create comparative data between commercial and Medi-Cal populations. Executive Director Romero proposed that this report be published biannually instead of annually. Mr. Shapiro requested that this be a public report rather than a report to the legislature. Ms. O'Sullivan emphasized that the report should be readable and readily available.

PUBLIC COMMENT

1. **Ms. Dodd-**ANA, California Regarding the New Quality Information Development discussion, Ms. Dodd urged against limiting the data set. She felt that it would be an error to require a data element to be deleted whenever a new data element is added.

2. **Ms. Stephanie Munoz** Ms. Munoz cautioned against over-regulation. She stated that the government's duty is to provide a level playing field for competition.

V. ADJOURNMENT - 5:14 PM

Before adjourning the meeting, Chairman Enthoven indicated that the following papers would be discussed at the November 25 Task Force meeting: 1) Improving the Dispute Resolution Process; 2) Consumer Information, Communication and Involvement; 3) Improving the Practice of Medicine; and 4) Case Study on Women's Health.

Chairman Enthoven then adjourned the meeting after hearing and seeing no objection.

Prepared by: Lawrence Ahn